

Summary of Changes to HR 2768
Made by Chairman's Amendment in the Nature of a Substitute
Markup of "Medicare Regulatory and Contracting Reform Act of 2001"
October 2001

<i>Section</i>	<i>Page</i>	<i>Explanation of Change</i>
3	6	Inserts "operational" before "error" on line 4.
3	6	Includes a new (c) provision on lines 6-20 requiring the Comptroller General to conduct a study to determine the feasibility and appropriateness of establishing in the Secretary and the Secretary's contractors the authority to provide legally binding advisory opinions on appropriate interpretation and application regulations to carry out the Medicare program. Such study shall examine the appropriate timeframe for issuing such advisory opinions, as well as the need for additional staff and funding to provide such opinions.
6	22	Adds a provision on lines 7-9, to permit the Small Provider Technical Assistance Demonstration Program to be used for information and assistance regarding Medicare policies and procedures, including coding and reimbursement.
7	25	On line 12, insert "within the Department of Health and Human Services" after Ombudsman.
8	26	Replace lines 28-30 with the following: "...shall develop and implement a plan under which the functions of administrative law judges responsible for hearing cases under this title...".
8	27	On line 1, delete "such" before administrative law judges. Insert a new (3) on lines 23-31 requiring that "the Secretary shall submit to the Committee on Ways and Means of the House of Representatives, the Committee

on Finance of the Senate, and the Comptroller General the terms of the plan developed under paragraph (1). No later than September 1, 2003, the Comptroller General shall submit to such Committees a report containing an evaluation of the terms of such plan.”

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| 9 | 32 | Changes provision on line 37 of page 32 and line 1 of page 33 to prohibit recovery of overpayments until after reconsideration at the Qualified Independent Contractor level of appeal, rather than the Administrative Law Judge level. |
| 11 | 40 | Adds a requirement on lines 17-19 that one of the pilot programs shall focus on an alternative method to detailed guidelines based on physician documentation of face to face encounter time with a patient. |
| 12 | 42 | On line 27 inserts a requirement that the coordinated review will occur when requested by the applicant, with the Secretary retaining the flexibility to determine if such a coordinated review for that technology is feasible. |
| 12 | 43 | On line 21 striking “senior staff member” and replacing it with the Executive Coordinator for Technology and Innovation. |
| 12 | 43 | On line 22 added that the coordinator could be designated as well as appointed. |
| 12 | 43 | On line 31 changes the Council as the appointing body to the Secretary in addition gives the secretary authority to designate an individual as well as appoint. |
| 12 | 43 | On line 31 replacing “assist” with oversight. |
| 12 | 45 | Adds a new section (C) that asks the Institute of Medicine in its report to examine the advantages and disadvantages of local coverage decision-making. Renumbering the existing section (C) as (D). |

12	46	Adding a new section (E) that asks the Institute of Medicine to examine the advantages and disadvantages of maintaining local medicare contractor advisory committees.
12	46	Deleting section (f) on Assignment of Health Care Common Procedure Level II coding system.
12	46	Adding a new section (f) creating a public process for new lab tests.
12	46	Adds on line 19 “by regulation” as the process for reporting procedures for reporting lab tests.
12	47	Replaces (i) on the identification of the rules and assumptions for lab tests with a requirement that the Secretary set forth the criteria for making determinations.
12	48	Clarifying the section (b) includes physician services as well as hospital services.
12	49	Adds a requirement (c) that the Secretary submit overdue reports on the therapy expenditure cap.
12	49	Adds (d) that permits hospice services to have services furnished under arrangement under extraordinary or non-routine circumstances. The originating hospice must bill for the service.